Alternative Payment Methodologies for Certified Community Behavioral Health Clinics

Introduction

The Certified Community Behavioral Health Clinic (CCBHC) model is an organizational and care delivery model for behavioral health centers that is being piloted to sustainably move Texas to an integrated, coordinated, and effective healthcare delivery system. At minimum, the CCBHC model requires behavioral health centers to integrate mental health and substance use services with targeted medical testing and screening. Managed Care Organizations (MCOs) that work with centers identified as CCBHCs will be required to use an appropriate value based payment methodology with the centers to begin no later than September 1, 2018.

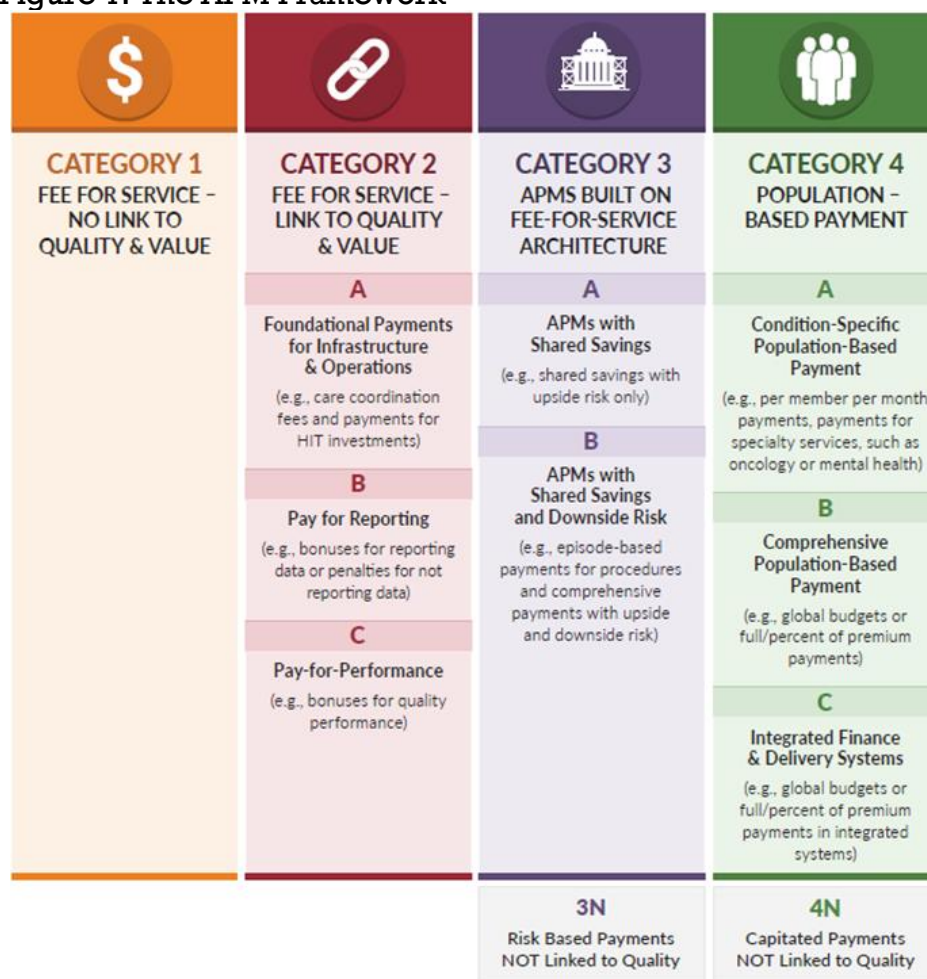Centers that have met CCBHC criteria and are participating in the CCBHC pilot (CCBHCs) are as follows:
- Bluebonnet Trails Community Services
- Burke
- Integral Care
- Helen Farabee Centers
- Montrose
- StarCare Specialty Health System
- Tarrant MHMR
- Tropical Texas

Health and Human Services Commission (HHSC) hosted calls with each MCO contracted with CCBHCs over the last few months to discuss current and upcoming approaches to integrated behavioral health care and alternative payment methodologies (APMs). From these calls, HHSC compiled and examined all of the notes to identify common themes and MCO priorities for using APMs in behavioral health care. As a result, HHSC has selected four preferred value based APMs that would be most appropriate for the goals of CCBHC pilot period.

Alternative Payment Methodologies

Within the Health Care Payment Learning & Action Network (HCP-LAN) APM Framework[1] (Figure 1), HHSC identified a set of four preferred methodologies that would be appropriate for achieving the goals of the CCBHC project and would be in accordance with the experience level of the MCOs and centers. Examples of each of the models are identified in Figure 1, and are discussed in further detail in the referenced HCP-LAN document.

Figure 1. The APM Framework

CATEGORY 1 FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE – LINK TO QUALITY & VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION – BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	**A** APMs with Shared Savings (e.g., shared savings with upside risk only)	**A** Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	**B** APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	**B** Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		**C** Integrated Finance & Delivery Systems (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	**4N** Capitated Payments NOT Linked to Quality

Retrieved from: http://hcp-lan.org/workproducts/apm-framework-onepager.pdf

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[1] Health Care Payment Learning & Action Network. *Alternative Payment Models (APM) Framework*. July 11, 2017. Retrieved from: https://hcp-lan.org/groups/apm-refresh-white-paper/

Preferred Methodologies

All MCOs and CCBHCs will engage in an APM for Fiscal Year 2019. The following methodologies were either identified by MCOs as preferred methodologies or are currently in place for at least one MCO and site.

- Category 2A - Foundational Payments for Infrastructure and Operations
- Category 2C - Pay-For-performance
- Category 3A - APMs with Shared Savings
- Category 4A - Condition-Specific Population-Based Payment

These methodologies have also been identified by HHSC to be in alignment with state level quality initiatives.

Alternative Methodologies and Arrangements

If there are other APMs that MCOs and CCBHCs are currently designing or are in the process of negotiating that fall outside of scope of the preferred APMs, MCOs and CCBHCs must provide information to HHSC for approval.

Evaluation

When considering quality metrics to evaluate APMs, MCOs should choose one or more measures that are currently being used for the CCBHC pilot. Table 1 lists the current measures that CCBHCs are expected to meet which can be collected using encounter data. CCBHCs are also collecting clinic level data that will be required for reporting during the CCBHC pilot period. These measures may also be considered for APMs, and are listed in Table 2.

Table 1. State Reported Measures

Potential Source of Data	Measure or Other Reporting Requirement	National Quality Forum Measure (# if endorsed)
URS	Housing Status (Residential Status at Admission or Start of the Reporting Period Compared to Residential Status at Discharge or End of the Reporting Period)	N/A
Claims data/Encounter data	Follow-Up After Emergency Department for Mental Health	2605
Claims data/Encounter data	Follow-Up After Emergency Department for Alcohol or Other Dependence	2605

Claims data/ encounter data	Plan All-Cause Readmission Rate (PCR-AD) (see Medicaid Adult Core Set)	1768
Claims data/ encounter data	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications	1932
Claims data/ encounter data	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (see Medicaid Adult Core Set)	No
Claims data/ encounter data	Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (see Medicaid Adult Core Set)	0576
Claims data/ encounter data	Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (see Medicaid Child Core Set)	0576
Claims data/ encounter data	Follow-up care for children prescribed ADHD medication (see Medicaid Child Core Set)	0108
EHR, Patient records	Initiation and engagement of alcohol and other drug dependence treatment (see Medicaid Adult Core Set)	0004
MHSIP Survey	Patient Experience of Care Survey/Family Experience of Care Survey	N/A

Table 2. Clinic Reported Measures

Potential Source of Data	Measure or Other Reporting Requirement	National Quality Forum Measure (# if endorsed)
EHR, Patient records, Electronic scheduler	Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients	N/A
EHR, Patient records	Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up	0421
EHR, Encounter data	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (see Medicaid Child Core Set)	0024

EHR, Encounter data	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	0028
EHR, Patient records	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	2152
EHR, Patient records	Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment (see Medicaid Child Core Set)	1365
EHR, Patient records	Adult major depressive disorder (MDD): Suicide risk assessment (use EHR Incentive Program version of measure)	0104
EHR, Patient records	Screening for Clinical Depression and Follow-Up Plan (see Medicaid Adult Core Set)	0418
EHR, Patient records Consumer follow-up with standardized measure (PHQ-9)	Depression Remission at 12 months	0710

Summary

MCOs and CCBHCs will be required to establish an APM arrangement within the proposed categories that is appropriate for member size, previous experience with APMs, and ability to manage risk, with the intention of building provider capacity to continue to engage in APMs after the CCBHC pilot period. Implementation of approved methodologies must occur on or before September 1, 2018.